Wright Smiles Pediatric Dentistry

Date _____

Patient Updated Information

Name: _____ Preferred Name: _____

Birth date: _____ Age: _____ Social Security #: _____

☐ Male ☐ Female Hobbies: _____

Home Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____

Account Email Address: _____

Mother's Name: _____ Birth Date: _____

Social Security #: _____ Work Phone #: _____ Cell Phone #: _____

Father's Name: _____ Birth Date: _____

Social Security #: _____ Work Phone #: _____ Cell Phone #: _____

Dental Insurance Information

Policy Holders Name: _____ Birth Date: _____

Social Security #: _____ Employer: _____

Insurance Name & Phone #: _____ Id #: _____

Has this patient had ANY history of difficulty with ANY of the following ? If YES, please check.

☐ AIDS/HIV	☐ Cancer	☐ Liver Disease
☐ ADD/ADHD	☐ Cerebral Palsy	☐ Measles/Mumps
☐ Anemia/Blood Disorders	☐ Chicken Pox	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Sickle Cell Disease/Trait
☐ Autism	☐ Epilepsy/Seizure's	☐ Sinus Problems
☐ Behavioral/Sensory Issues	☐ Hearing Impaired	☐ Thyroid Disease
☐ Birth Defects	☐ Heart Disease/Heart Murmur	☐ Tuberculosis
☐ Bladder Problems	☐ Hepatitis	☐ Other:
☐ Brain Damage/Mental Retardation	☐ Kidney Disease	_____

Allergies: _____

Medications: _____

Emergency Contact

In the event of an emergency, please list contact NOT living with you:

Name: _____ Relationship: _____ #: _____

Name: _____ Relationship: _____ #: _____

I, being the parent or guardian of _____ do hereby confirm that all above information is accurate and up to date. I fully understand that it is my responsibility to submit in writing to Wright Smiles Pediatric Dentistry if such above information changes. I request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays, and Fluoride, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Signature of Responsible Party: _____ Date: _____ /_____ /_____